

outcome in mild cases and an unfavorable outcome in patients whose responses were absent, indicating brain death, but failed to identify unfavorable outcome in 13 of 42 patients (31%), including 8 patients (19%) who sustained cerebrocortical death. Bilateral absence of cortical evoked responses proved an accurate discriminator. Four patients in this group underwent neuropathologic examination and showed widespread cortical and thalamic destruction, with acute ischemic changes of cortical neurons in those of short survival and frank necrosis of the pseudolaminar type after longer survival.

Patients with bilaterally delayed or attenuated cortical responses had an uncertain prognosis, as some died without awakening. One patient in this group underwent neuropathologic examination and was found to have widespread laminar necrosis with islands of preserved parietal cortex.

Electrocerebral silence reliably predicted unfavorable outcome but was found on initial examination in only 13 of 23 patients (57%) who died without awakening.

Previously reported prognostic factors in hypoxic-ischemic coma such as age, cardiac mechanisms, hypotension, serum glucose levels, and EEG abnormalities other than electrocerebral silence would not have predicted poor neurologic outcome in our patients. While cerebrospinal fluid creatine kinase BB isoenzyme values generally correlated with the extent of brain damage and with neurologic outcome, two of six patients who died without awakening had misleadingly low values.

Our results suggest that conventional scales that rely upon residual brain-stem function will fail to identify patients who have sustained severe and irreversible damage to the cerebral cortex who will not awaken. Bilateral absence of cortical evoked potentials is the most reliable early guide to unfavorable outcome in hypoxic-ischemic coma.

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## Public Health in California

TO THE EDITOR: Here are two public health concerns that we wish to bring to the attention of your readers.

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### Record Increase of Syphilis in California

In the past 18 months, California has experienced a major increase in the number of reported cases of primary and secondary syphilis. Health care providers should be aware of this increase so that appropriate diagnostic and therapeutic interventions can be undertaken.

During the past five years, the incidence of primary and

TABLE 1.—Change in Incidence of Primary and Secondary Syphilis From 1983 to 1986 According to Population Group

Population Group	Change in Incidence	
	Cases	Percent
White males . . . . .	-1,147	- 55
White females . . . . .	+ 90	+ 52
Black males . . . . .	+ 515	+ 52
Black females . . . . .	+ 544	+233
Hispanic males . . . . .	+ 435	+ 33
Hispanic females . . . . .	+ 190	+105

secondary syphilis in California, as a whole, has not reflected the successive yearly decreases that have been reported for the nation. Small fluctuations in incidence were observed from 1982 through 1985, but in 1986 a 35% increase in cases was reported, with a record number of cases (5,897) being reported for the year. Likewise, in the first six months of 1987, reported cases of primary and secondary syphilis were 51% greater than for the first six months of 1986 (3,641 versus 2,412).

Eight of California's 61 local health jurisdictions reported significant increases (over 20 additional cases) for the first six months of 1987, compared to 1986. These were the counties of Contra Costa, Fresno, Los Angeles, Sacramento, San Bernardino, San Diego, and Tulare, and the city of Long Beach.

Conversely, four major jurisdictions reported significant decreases: the counties of Orange, San Joaquin, Santa Clara, and San Francisco. These reductions were achieved predominantly in high-risk populations—that is, homosexuals or Spanish-speaking undocumented single men (whose infections usually result from sex with prostitutes), or both. Successive yearly decreases have been noted in San Francisco from 1982 through 1986 and have been ascribed to acquired immunodeficiency syndrome (AIDS)-related education campaigns for safer sex practices.

Except for white men, in whom the incidence of primary and secondary syphilis has declined in recent years, increases have been reported in all other major population groups in California since 1983 (Table 1).

Of considerable concern is that case investigations have revealed an ever-increasing association between substance abuse and the incidence of syphilis throughout the state, and, notably, more cases are being identified in young women who engage in part-time prostitution for cocaine—especially "crack" cocaine. The reason for this emerging sex-for-cocaine association probably is due to cocaine's relatively short-lived effect, which requires the user to engage in sex-for-cocaine more frequently. Further, women engaging in part-time prostitution have a greater likelihood of contracting sexually transmitted diseases.

Also of great concern is the sudden and unprecedented increase (79%) in the number of cases of congenital syphilis reported in 1986, with the number of California newborns having definite or probable congenital syphilis rising from 34 in 1985 to 60 in 1986. The increased incidence in black newborns was even more pronounced: 700% (3 cases in 1985 to 24 in 1986). The possible relationship of this to changes in the number of pregnant women having no or delayed prenatal care warrants further investigation. Clearly, practitioners need to perform serologic tests in their pregnant patients, repeating them at each trimester, if indicated, and to be especially vigilant for lesions that might reflect syphilis.

In addition to the concern about congenital syphilis, the increase in primary and secondary syphilis also prompts concern about the control of AIDS, since a history of syphilis is associated with increased risk of human immunodeficiency virus (HIV) infection in both homosexuals and heterosexuals.

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### **California's Male Suicide Rate at Record High**

In 1985, the last year for which complete statistics are available, there were 3,782 suicide deaths among California residents and a record number of male suicides. This is the overall highest number of self-inflicted deaths in California since 1977.

California's 1985 suicide rate of 14.5 deaths per 100,000 population was 0.7% greater than the 1984 rate of 14.4, compared to national suicide rates of 12.0 and 12.3 for 1985 and 1984, respectively. California accounted for 13.2% of all suicides (28,620) in the United States in 1985.

The rise in the number of California suicide deaths was due to an increase in male suicides, with the reported 2,878 male suicides in 1985 being the highest number ever recorded. Conversely, the number of female suicides in 1985 (904) was the lowest ever recorded in California. Similarly, the 1985 California male suicide rate was 22.5 deaths per 100,000 population (the highest rate since 1978), while the female suicide rate of 6.9 per 100,000 was the lowest recorded since 1970. Both of these 1985 rates continued recent trends for California, with the rate for males increasing 3.2% and the rate for females decreasing 4.2%, compared to 1984.

The greatest increase in the number of male suicide deaths was in men aged 65 and older, with the 1985 rates for men aged 65 to 74 and over 75 rising 18.9% and 36.4%, respectively, compared to the 1980 rates. Notable increases in the incidence of suicide in 1985 were also seen among young males, with increases of 7.6% and 46.2% in the age groups 15 to 19 and 5 to 14 years, respectively, although the actual numbers were much smaller than for older men.

In contrast to males, 1985 female suicide rates in California decreased for all ages except older teenagers and women over 75. The rates for these age groups increased from 3.5 to 4.9 deaths per 100,000 and from 9.0 to 11.2, respectively, compared to 1984 rates. The largest decrease (19.7%) was for the 45 to 64 age group, in which the rate dropped from 13.2 to 10.6 deaths per 100,000.

The reasons for the notable increases in male suicides in California during recent years are not clear, and this trend warrants further investigation, especially in regard to preventive interventions.

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### **Health Care Costs**

TO THE EDITOR: Our medical care system, like all human endeavor, is not perfect; it shares the problems of our entire economy. What is disturbing in recent years is the widely

orchestrated claim of a crisis, allegedly confined solely to health care, with a blind spot for its roots in the more important general economy. A brief look backward into such roots may be helpful in your quest<sup>1</sup> for a different insight into our medical care problems (and perhaps complement your own effort).<sup>2</sup>

Cost comparisons of medical care over time usually end up calling the cost rises "unique" and "monumental," thereby neglecting the historic importance of seven decades of monetary expansion in the entire economy. This refers essentially to the almost constant and progressive loss of the purchasing power of the dollar from such monetary expansion above that calculated for the growth of population and the total economy, innovations, improved technology, and so forth.<sup>3</sup>

In my lifetime, there was a span of years when the total expenditures of the federal government were less than \$1 billion a year. Closer to today, federal outlays grew from \$33 billion in 1946 to \$1.1 trillion in 1986—a 3,200% increase.<sup>4</sup> Almost \$3 billion was spent each day by the federal government in 1986. (Incidentally, our indebtedness—overspending—also began in the mid-1940s.) We are not talking about the same dollar then and now. Even calculating "stable" dollars for comparison is subject to error. What we end up with is a continuous cheapening of the dollar. And such cheapening is being done openly now!

Criticism of our medical care system goes back a full century to the time when new (socialist) ideas for reform crossed the Atlantic. The motive has been the introduction of national health insurance. We are reaping the fallout from generations of attacks by advocates of a compulsory public sector program for all. The conflict climaxed with a turbulent array of federal proposals from 1939 to 1961. There was resistance from the public and the American Medical Association, but so many years of repetitious promotion gained a foothold. Despite significant disapproval, Medicare was passed (1965) during the emotional upheaval following President Kennedy's assassination. Further promotion was placed on the back burner when Medicare's problems with understated costs and enormous expansion of demand with rapid increases in such costs began to surface. It was a brief interval, however, and the encounter continued thereafter.

Once-popular comparisons with the British Health Service lost their appeal, but comparisons with the Canadian system promptly filled the gap. Nonetheless, the old conclusion of international comparisons still stands today: "We still have a long way to go in evaluating overall health systems performance."<sup>5</sup> The reason? Lack of completeness of financial data of cost from abroad.

Open advocacy for a national program is at least open and constitutes a legitimate difference of opinion. But it is perplexing to speculate at what is really behind some proposals for cost containment. The links in some argumentative chains could properly be interpreted as an attempt to subvert the foundation of medical insurance.<sup>6</sup> Why? Incentives to what?

Those unable to grasp the enormous probing potential ("outreach") of the federal government to assemble, disseminate, and promote information need to ponder over a 1977 report on national health insurance by the old, familiar Department of Health, Education, and Welfare. What would be different from what we have now? Centralized control (rules and regulations) by the federal government. Regrettably, its performance record is not persuasive, especially since 1977, when the cumulative result of years of overspending and piling